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RESEARCH ARTICLE

A Threat to Sustainable HealthCare Services? Examining the Effect of Structural Violence on the Policy Outcomes of Lagos State Health Insurance Scheme among Enrolled Junior Officers in the Lagos State Ministry of Works and Infrastructure

Moyosoluwa Dele-Dada[1*], Daniel Gberevbie[2], Fadeke Olu-Owolabi[3], Abolaji Atobatele[4]

[1,2,3,4] Department of Political Science and International Relations, Covenant University, Ota

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***Corresponding Author:**

moyosoluwa.dele-dadapgs@stu.cu.edu.ng

ABSTRACT

In Nigeria, citizens face challenges accessing quality healthcare despite the National Health Insurance Scheme. Decentralizing the scheme's implementation to states, including Lagos, aimed at universal health coverage, has not effectively addressed disparities. The implementation of the Lagos State Health Insurance Scheme seems to perpetuate structural violence, reflected in increased expenses, discrimination, substandard services, and preferential treatment. Furthermore, the sustainability of the scheme remains questionable due to these systemic issues. Therefore, this study explores the effect of structural violence on policy outcomes of the Lagos State Health Insurance Scheme among enrolled junior officers in the Lagos State Ministry of Works and Infrastructure, using primary and secondary sources of data. Findings show unintended consequences emanating from the implementation of the policy such as dissatisfaction, provider shifts, non-adherence to treatment plans, increased compensation claims, and erosion of trust among users. From these findings, the study, therefore, recommends insurance broadening coverage, addressing medical conditions comprehensively, and implementing incentive programs for quality healthcare delivery, standards adherence, patient satisfaction and long-term sustainability within the scheme.

INTRODUCTION

The burgeoning recognition of the paramount importance of health in the domains of human well-being and economic progress is gaining momentum on a global scale. Consequently, nations are augmenting their commitments and allocations towards initiatives and systemic modifications that aim to ameliorate health outcomes, advance societal progress, and ensure sustainability in healthcare systems (Health Policy Commission, 2023). However, even the most developed nations are grappling to align their fiscal frameworks with the unremitting surge in healthcare expenditures. The pervasive economic downturn further underscores the intricate complexities intertwined within the domain of healthcare expenditure (Health Policy Commission, 2023).

Moreover, over 50 per cent of the global population faces barriers in accessing vital healthcare services, with disparities in both affordability and availability of such healthcare services persisting

worldwide (World Health Organization, 2022). While some regions have made progress in increasing the availability of fundamental health services like family planning and infant immunisation, the absence of financial safeguards has resulted in mounting economic burdens on families who must bear these expenses from their resources. This challenge is not limited to less economically developed areas; even relatively prosperous regions such as Eastern Asia, Latin America, and Europe are witnessing a rising number of individuals allocating at least 10 percent of their household budgets towards out-of-pocket health expenditures (World Health Organization, 2017).

Furthermore, these inequalities in terms of disparities in affordability, availability and quality of healthcare services, high out-of-pocket payments, and absence of financial safeguards in healthcare services are not solely confined to variations between different countries; they are equally pronounced within nations themselves. Since the mid-20th century, national governments and international organizations have committed to closing the gap between the most and least advantaged in terms of healthcare services (The Lancet Global Health, 2016). Researchers in global health have examined and delineated the distinctions between the most and least disadvantaged, and policymakers have employed this data to reduce inequalities, with some success in both high-income and low- to middle-income countries (LMICs). Nonetheless, disparities in affordability, availability, and quality of healthcare services persist. In regions like Africa, limited access to healthcare services, mainly due to financial barriers, profoundly affects disease rates and health outcomes, especially in low-to-middle-income countries (Adugna, Nabbouh, Shehata & Ghahari, 2020). Although the World Health Organization continues to emphasises the critical role of health financing in strengthening health systems and improving overall human well-being, financial inclusion in healthcare remains relatively inadequate in Sub-Saharan countries, Nigeria included (Sarpong & Nketiah-Amponsah, 2022; World Health Organization, 2017).

In Nigeria, the concept of Social Health Insurance was proposed in 1962 through the Lagos Health Bill, but its progress was regrettably halted for undisclosed reasons (Balogun, 2022). Post-independence, healthcare funding in Nigeria predominantly came from the government, offering free universal healthcare mainly in public healthcare facilities. However, this practice ceased due to the 1980s global oil price slump, which diminished oil export revenues—a major financing source (Ekhator-Mobayode, Gajanan & Ekhator, 2022). In 1985, a committee set up by the Ministry of Health affirmed the feasibility of health insurance in Nigeria, outlining plans for its launch by mid-1991. Nonetheless, the flagship National Health Insurance Scheme (NHIS) was only signed into law in 1999, eight years beyond the initial launch projection, and finally launched in 2005. The NHIS outlines objectives including universal access to quality healthcare for Nigerians, protection of families from crippling medical expenses, containment of rising healthcare costs, equitable distribution of healthcare expenses across income groups, even distribution of healthcare facilities within the nation, and ensuring funds for improved services (Abiola et al., 2019). Unfortunately, evidence suggests that these objectives remain largely unmet.

The central goal of the insurance scheme is to decrease dependency on out-of-pocket payments, which disproportionately burden the less affluent and reflect inequities in the healthcare system. However, initially, the NHIS covered solely federal government workers, constituting less than 5 percent of Nigeria's population. Coverage from other insurance agencies such as private health insurance and community-based health insurance encompassed less than 1 percent (Alawode & Adewole, 2021). This points to a mere 6 percent coverage. As a result, a striking 94 percent had to pay for healthcare out-of-pocket (OOP). This reality contributes to the elevated mortality rate among economically disadvantaged individuals from easily preventable and treatable diseases, such as malaria. According to World Bank (2021), 39.1 percent of Nigerians live below the international poverty line, while 61.3 percent grapple with multidimensional poverty (National Bureau of Statistics, 2022). In a country where a significant majority falls below the poverty line, the inability

of certain social strata to access healthcare presents a troubling and overtly significant public health challenge.

To overcome the challenge of limited coverage within the NHIS and ensure healthcare accessibility for all social strata, the NHIS decentralized the implementation of the country's social health insurance programme to the states in 2014. This initiative aimed to accelerate the nation's progress toward achieving universal health coverage (Alawode & Adewole, 2021). Subsequently, in 2014, the Lagos State government introduced its health financing policy, giving rise to the Lagos State Health Insurance Scheme (LSHIS). This initiative aimed to address financial disparities, develop long-term health financing strategies, and ensure the sustainability of healthcare services. However, it becomes evident that the implementation of the Lagos State Health Insurance Scheme has not effectively remedied the pre-existing deficiencies in the healthcare system. Instead, the implementation of this scheme seems to perpetuate structural violence as seen in the amplification of out-of-pocket expenses, discrimination between individuals relying on private or public health insurance, delivery of substandard healthcare services, and the privileging of medical care for those who can afford to pay directly (Shobiye et al., 2021). Moreover, the scheme operates under the premise that registered healthcare providers extend services to scheme enrolees at a reduced cost, with subsequent reimbursement from the government. Despite this framework, both public and private healthcare providers confront challenges stemming from inadequate tariffs and persistent delays in claims processing and payments. Additionally, instances arise wherein healthcare service providers render care to patients but encounter non-reimbursement due to discrepancies between the provided care and the scope outlined in the agreement between the government and providers (Shobiye et al., 2021). The implications of this have been profound and multifaceted in that it has resulted in unequal access, out-of-pocket payments, underutilization, and other significant challenges for healthcare users. In response to these challenges, the Lagos State government took proactive steps to facilitate residents' access to the scheme's benefits. It mandated that residents encountering obstacles while seeking quality healthcare at any facility could report their concerns by contacting the customer service of the Lagos State Health Management Agency directly from the facility. This approach was aimed at ensuring swift issue resolution. The government also implemented sanctions against facilities intentionally denying patients healthcare services or taking advantage of them. Furthermore, the government introduced the flexibility for registered facilities to opt out of the scheme if they deemed the reimbursement insufficient (Aikulola, 2021).

Despite the government's efforts to address the challenges faced by enrollees in enjoying the provisions of the Scheme, enrolled residents continue to encounter rising out-of-pocket expenses. Furthermore, they receive subpar healthcare services, with a preference shown to those who can afford out-of-pocket payments (Roberts, Agboola, Oshunniyi, & Roberts, 2018; Shittu & Afolabi, 2020). Contrary to its aim of enhancing quality, accessible and affordable healthcare access for all Lagos State residents, the current implementation of the Lagos State Health Insurance Scheme inadvertently perpetuates structural violence. The same challenges that dominated the healthcare landscape before the decentralization of the national social insurance scheme persist in Lagos State, despite the establishment of the scheme and governmental interventions. Consequently, there is a compelling need for a research inquiry dedicated to the investigation of how structural violence has exerted influence on the policy outcomes of the Lagos State Health Insurance Scheme, with a concurrent focus on the formulation of strategic policy recommendations aimed at bolstering the scheme's efficacy in mitigating structural violence, ensuring sustainability and improving health outcomes.

Research Objectives

Investigate how the denial of quality healthcare services among enrolled junior officers has affected the policy outcomes of the Lagos State Health Insurance Scheme;

Examine how inequity in healthcare service provision among enrolled junior officers has affected the policy outcomes of the Lagos State Health Insurance Scheme;

Examine the extent to which discrimination in healthcare service provision among the enrolled junior officers has affected the policy outcomes of the Lagos State Health Insurance Scheme; and

Investigate how continuous out-of-pocket expenses among enrolled junior officers have affected the policy outcomes of the Lagos State Health Insurance Scheme.

METHODS

This study adopted primary and secondary sources of data collection. The primary data consisted of data collected via a questionnaire and interview. The questionnaire was administered face-to-face to junior officers in the Lagos State Ministry of Works and Infrastructure. The population of junior officers in the ministry stands at 348. The sample size stood at 251 following the Krejice and Morgan sample size determination table at a 2.5% margin of error. An additional 20 copies were added to make up for copies of the questionnaire not returned or filled correctly. The semi-structured interview was conducted using purposive sampling on officials of the Lagos State Health Management Agency officials (LASHMA) respectively. This approach enabled an in-depth exploration of the research problem and established a good rapport between the researcher and the respondents.

Secondary sources of data collection were also adopted in this study. The secondary data was sourced from peer-reviewed journals from databases like Scopus, Web of Science, and Science Direct among others. The use of multiple data sources helped to achieve the research objectives and provide a comprehensive understanding of the research problem.

The data collected for this study were analysed descriptively and inferentially. A statistical data technique was employed to test the null hypotheses of the study at a 0.05 level of significance, namely, Ordinal Regression Analysis. This analysis enabled the investigation of the effect of structural violence (measured by denial of quality healthcare services, inequity, discrimination, and continued out-of-pocket payment) on the policy outcomes of the Lagos State health insurance scheme (measured by quality, accessibility, affordability, and equality). The Statistical Package for Social Sciences (SPSS) v26 was utilised in the study. The information gathered through one-on-one interviews was transcribed and analysed using thematic analysis to complement the results from the questionnaire. Thematic analysis facilitated the identification and interpretation of patterns in the data, enabling a deeper understanding of the research problem.

Understanding the Concept of Structural Violence

Structural violence, as conceptualized by Norwegian sociologist Johan Galtung in 1969, is a form of violence that is embedded within the social, political, and economic structures of a society (Alexander, 2018). It is a phenomenon that hinders individuals, groups, and societies from achieving their full potential by imposing limitations that are rooted in the structures of power. Macassa, McGrath, Rashid, & Soares (2021) similarly defined structural violence as the social, economic, legal, political, religious, and cultural structures that obstruct the realization of fundamental human needs. According to Galtung (2023), structural violence represents a deliberate deprivation of these needs by powerful actors, a process that unfolds through the gradual erosion and ultimately the destruction of human life. Structural violence in this study therefore describes the actions and inactions of existing administrative structures that result in the systemic deprivation of fundamental needs and, consequently, the occurrence of avoidable distress.

In a study by Rylko-Bauer & Farmer (2016), structural violence is established to be inherent in the political and economic structures of society and is characterized by the infliction of harm on individuals who are not responsible for perpetuating these inequalities. Unlike physical violence, structural violence results from institutionalized and systemic inequalities that exist within society.

The authors argue that individuals may cause significant harm to others inadvertently, as they perform their regular duties within the structures of society.

The constitution of societal structures, such as medical services, jobs, transportation, food, and shelter, are closely linked to the material resources available to individuals (Kraus & Torrez, 2020) Jackson & Sadler (2022) note that unequal access to these resources, as well as political power, education, health care, or legal standing, constitutes forms of structural violence that cause harm to individuals. Meckel (2021) posits that structural violence is interrelated with social injustice and the social machinery of oppression, resulting in differential access and creating a vicious cycle of poverty and deprivation that impairs the somatic and mental realization of individuals' potential. Structural violence can manifest in various forms, including differential access, discrimination, and inequality, and can become normalized and invisible, forming part of the fabric of society (Rylko-Bauer & Farmer, 2016). Systemic racism, where policies and practices in society lead to the disadvantage of people of colour, has been identified as a form of structural violence in Europe (Hamed, Thapar-Björkert, Bradby, & Ahlberg, 2020). Furthermore, Hosken (2020) highlights income inequality as a form of structural violence, where the distribution of wealth in society is heavily skewed, leading to the impoverishment of many individuals.

The effects of structural violence are apparent in health disparities, education inequality, and the lack of access to basic needs such as food and shelter (Lee, 2016). The intersection of these inequalities often amplifies their impact, leading to additional disadvantages and increased suffering for those who are impacted. Unlike physical violence, structural violence is not immediately discernible since it is ingrained in societal structures such as economic, legal, political, religious, and cultural institutions. Structural violence often leads to suffering and mortality as much as direct violence; however, it is a more gradual, nuanced, prevalent, and complex phenomenon that is difficult to remedy (Macassa et al., 2021).

FINDINGS AND DISCUSSION

Table1: Demographic Data

		Frequency	**Percentage**
Gender	Male	114	43.5
	Female	148	56.5
	Total	262	100.0
Age	20-35 years	49	18.0
	36-50 years	197	75.2
	51-65 years	16	6.8
	Total	262	100.0
Marital Status	Single	44	16.8
	Married	194	74.0
	Divorced	10	3.8
	Separated	14	5.3
	Total	262	100.0
Highest Educational Qualification	OND	22	8.4
	HND	42	16.8
	B.Sc.	196	74.8
	Total	262	100.0
Length of Service	Less than 5 years	39	14.9
	5-10 years	203	77.5
	Above 10 years	20	7.6
	Total	262	100.0

Note. Field Survey (2023)

Table 1. reveals the frequency distribution of the respondents by gender, age, marital status, highest educational qualification, place of work and length of service. According to the table, 114 (43.5%) were male, while only 148 (56.5%) were female respondents. This is due to the fact that majority of those who responded were females compared to males. Furthermore, the frequency distribution of respondents' age shows that the majority of the respondents (75.2%) are within the age range of 36-50 years, 18.0% are within the age range of 20-35, 6.8% falls between the age range of 51-65 years.

The frequency distribution of the respondents' marital status reveals that most of respondents (74.0%) are married, 16.8% are single, 3.8% are divorced, 5.3% are separated. In addition, as seen in table 4.2, the majority of the survey respondents (74.8%) holds a first degree (Bachelor's degree), while 16.8% have a Higher National Diploma, 8.4% obtained an Ordinary National Diploma. Furthermore, the frequency distribution of the respondents' length of service shows that majority of the respondents (77.5%) have worked for 5-10 years, 14.9% have worked for less than 5 years, while 7.6% have worked above 10 years.

TEST OF HYPOTHESES

This section presents the results of the hypotheses tested to assess the relationship among the variables of the study. Ordinal Linear Regression was computed, with the aid of SPSS Version 28.

Hypothesis One

Ho: The denial of quality healthcare services among enrolled junior officers has not significantly affected the policy outcomes of the Lagos State Health Insurance Scheme.

Table 1: Parameter Estimates

							95% Confidence Interval	
		Estimate	**Std. Error**	**Wald**	**df**	**Sig.**	**Lower Bound**	**Upper Bound**
Threshold	[Quality = 1.75]	2.334	.471	24.540	1	.000	1.411	3.258
	[Equity = 1.81]	3.375	.472	51.121	1	.000	2.450	4.300
	[Accessibility = 1.88]	4.338	.494	77.200	1	.000	3.371	5.306
	[Affordability = 1.94]	4.625	.502	84.992	1	.000	3.642	5.608
Location	Denial of Quality	3.802	.276	110.638	1	.000	2.360	3.441

Table 1 shows a parameter estimate of a positive coefficient between the denial of quality health care service and policy outcomes of LSHIS. This means that for every one-unit increase in denial of quality healthcare service, there is a predicted increase of 3.802 in the log odds of being a higher level on policy outcomes of LSHIS. Also, the parameter estimates show that the denial of quality healthcare services significantly affects the policy outcomes of LSHIS. Therefore, the hypothesis which states that the denial of quality healthcare services among enrolled junior officers in the five selected ministries has not significantly affected the policy outcomes of the Lagos State Health Insurance Scheme is rejected. In other words, there is sufficient evidence to conclude that the denial of quality healthcare services among enrolled junior officers in the five selected ministries has significantly affected the policy outcomes of the Lagos State Health Insurance Scheme. This result is in tandem with the data gathered through interviews.

The representatives from the Lagos State Health Management Agency emphasized that the failure to provide high-quality healthcare services contradicts the essence of the program. They elaborated

that although the scheme promises quality healthcare services for its participants, some individuals are unable to fully benefit due to the actions of certain healthcare providers, hindering the effective achievement of the scheme's objectives. This implies that the scheme is not accomplishing its goals adequately for all participants. Furthermore, they acknowledged the scheme as a commendable initiative with achievable objectives. However, they noted that the lack of quality healthcare delivery by some providers has impacted the overall outcomes, though not entirely negatively. They highlighted that some individuals still derive benefits from the scheme, indicating that its effectiveness is affected to a reasonable extent. This should not be misconstrued as rendering the scheme useless or its goals unattainable. To ensure quality healthcare for all participants, everyone needs to fulfill their responsibilities. The representatives lamented that blame is often directed at their agency without recognizing the broader scope of the scheme. They emphasized the involvement of various stakeholders whose actions can influence the scheme's outcomes either positively or negatively.

Hypothesis Two

Ho: Inequity in healthcare service provision among enrolled junior officers has not significantly affected the policy outcomes of the Lagos State Health Insurance Scheme.

Table 2: Parameter Estimates

		Estimate	Std. Error	Wald	df	Sig.	95% Confidence Interval	
							Lower Bound	Upper Bound
Threshold	[Quality = 1.75]	.779	.373	4.367	1	.037	.048	1.510
	[Equity = 1.81]	1.696	.352	23.279	1	.000	1.007	2.385
	[Accessibility = 1.88]	2.554	.354	52.137	1	.000	1.861	3.248
	[Affordability = 1.94]	2.803	.357	61.591	1	.000	2.103	3.504
Location	Inequity	2.242	.223	92.123	1	.000	1.706	2.582

Table 2. shows a parameter estimate of a positive coefficient between inequity and policy outcomes of LSHIS. This means that for every one-unit increase in inequity, there is a predicted increase of 2.242 in the log odds of being a higher level on policy outcomes of LSHIS. Also, the parameter estimates show that the inequity has a significant effect on the policy outcomes of LSHIS. Therefore, the hypothesis which states that inequity in healthcare service provision among enrolled junior officers has not significantly affected the policy outcomes of the Lagos State Health Insurance Scheme is rejected. In other words, there is sufficient evidence to conclude that inequity in healthcare service provision among enrolled junior officers in the five selected ministries has significantly affected the policy outcomes of the Lagos State Health Insurance Scheme. This finding is somewhat in tandem with the data gathered through interview.

As per the statements from LASHMA interviewees, they assert that there is no inequity in the registration or provision of insurance. Eligibility is based on submitting necessary data and paying the premium. However, the interviewer raises concerns about the scheme's objective to provide accessible, affordable, equal, and quality healthcare, questioning if economic constraints for some junior officers contradict this objective. Interviewee 2 responds, stating that as long as individuals are employed, affordability is assumed, and monthly deductions from salaries are compulsory. These deductions make healthcare insurance coverage available to all, regardless of financial capacity. The interviewee emphasizes that healthcare is not free, but the scheme aids individuals in obtaining it at a subsidized rate. They clarify that health insurance coverage is provided based on fulfilling

requirements, irrespective of age, marital status, workplace, or injury. The interviewee acknowledges claims of denied access, disparities in care quality due to financial factors, age and misuse of insurance, emphasizing that such issues are frowned upon and thoroughly investigated for appropriate action. The repercussions of these challenges, including a lack of trust, accessibility problems, and instances of substandard care, are highlighted. These issues, according to the interviewee, undermine the scheme's objectives. They also observed that this lack of trust has undermined the overall effectiveness of the policy by discouraging enrollment and participation. Moreover, individuals now perceive that the scheme does not fulfill its promise of equitable healthcare, and question the legitimacy and fairness of the entire system.

Hypothesis Three

Ho: Discrimination in healthcare service provision among the enrolled junior officers has not significantly affected the policy outcomes of the Lagos State Health Insurance Scheme.

Table 3: Parameter Estimates

							95% Confidence Interval	
		Estimate	Std. Error	Wald	df	Sig.	Lower Bound	Upper Bound
Threshold	[Quality = 1.63]	3.208	.855	14.063	1	.000	1.531	4.884
	[Equity = 1.75]	4.140	.755	46.378	1	.000	3.660	6.619
	[Accesssibility = 1.81]	6.137	.758	65.545	1	.000	4.651	7.623
	[Affordability = 1.88]	7.141	.776	84.763	1	.000	5.621	8.662
Location	Discrimination	3.682	.391	103.734	1	.000	3.216	4.748

Table 3. shows a parameter estimate of a positive coefficient between discrimination and policy outcomes of LSHIS. This means that for every one-unit increase in discrimination, there is a predicted increase of 3.682 in the log odds of being a higher level on policy outcomes of LSHIS. Also, the parameter estimates show that discrimination significantly affects the policy outcomes of LSHIS. Therefore, the research hypothesis which states that discrimination in healthcare service provision among the enrolled junior officers has not significantly affected the policy outcomes of the Lagos State Health Insurance Scheme is rejected because there is sufficient evidence to conclude that discrimination in healthcare service provision among the enrolled junior officers in the five selected ministries has significantly affected the policy outcomes of the Lagos State Health Insurance Scheme. This finding is in tandem with the data gathered through interview.

According to statements from LASHMA interviewees, challenges within the health insurance system manifest not during the acquisition stage but rather when enrollees attempt to utilize their coverage. This issue has deterred some enrollees from consistently using the scheme. Discrimination against state-based and private insurance coverage has resulted in unequal access to healthcare services, impacting the equitable enjoyment of coverage. The consequence is a hindrance to receiving timely and appropriate care, potentially preventing individuals from fully utilizing the benefits offered by the health insurance scheme. Moreover, this discriminatory practice has instilled a sense of hesitation among some enrollees. Due to concerns about potential bias from healthcare providers, individuals may delay seeking medical attention until their conditions worsen, leading to underutilization of health services. Importantly, the mandatory renewal of health insurance, whether used or not, adds to the financial burden on enrollees. In response to the interviewer's prompt, Interviewee 2 concurred with the colleague's remarks, emphasizing that this issue has created a significant gap in healthcare access. The hesitation observed among enrollees extends to preventive

care, with individuals only seeking medical help when their situations become critical. Financially, enrollees are adversely affected when faced with demanding healthcare providers seeking additional monetary compensation. This discriminatory practice not only places a heavier financial burden on individuals with insurance coverage but also undermines the effective implementation and enforcement of health insurance policies. The interviewee highlighted cases of inconsistent treatment reported, raising doubts about whether healthcare providers adhere to stipulated processes.

Hypothesis Four

Ho: Continuous out-of-pocket expenses among enrolled junior officers have not significantly affected the policy outcomes of the Lagos State Health Insurance Scheme.

Table 4: Parameter Estimates

							95% Confidence Interval	
		Estimate	Std. Error	Wald	df	Sig.	Lower Bound	Upper Bound
Threshold	[Quality = 1.81]	1.092	.339	10.384	1	.001	.428	1.756
	[Equity = 1.88]	1.925	.343	31.505	1	.000	1.253	2.598
	[Accessibility = 1.94]	2.264	.347	38.882	1	.000	1.484	2.844
	[Affordability = 2.00]	2.328	.350	44.161	1	.000	1.642	3.015
Location	Out-of-pocket payment	1.601	.184	66.620	1	.000	1.141	1.862

Table 4. shows a parameter estimate of a positive coefficient between out-of-pocket payment and policy outcomes of LSHIS. This means that for every one-unit increase in out-of-pocket payment, there is a predicted increase of 1.501 in the log odds of being a lower level on policy outcomes of LSHIS. Also, the parameter estimates show that out-of-pocket payment significantly affects the policy outcomes of LSHIS. Therefore, the hypothesis that states that continuous out-of-pocket expenses among enrolled junior officers have not significantly affected the policy outcomes of the Lagos State Health Insurance Scheme is rejected because there is sufficient evidence to conclude that continuous out-of-pocket expenses among enrolled junior officers in the five selected ministries have significantly affected the policy outcomes of the Lagos State Health Insurance Scheme.

The interviewees from LASHMA emphasized that the financial burden imposed by the scheme could result in reduced satisfaction and negatively impact the well-being of enrollees. In instances where certain required care is not covered by the scheme, obtaining medical attention might become challenging, acting as a barrier to essential healthcare access. Not all enrollees may be willing to bear additional healthcare costs, leading to potential delays or even forgoing necessary care. Another significant concern raised is the high out-of-pocket expenses, which could result in non-adherence to recommended treatment plans or medications. This non-compliance poses a risk to the effectiveness of the health insurance policy, particularly in managing chronic conditions and preventing complications. If the perceived unaffordability of out-of-pocket expenses associated with the health insurance scheme persists, there is a risk that the policy may be deemed ineffective in achieving its primary goals of enhancing overall health and reducing financial barriers to healthcare.

DISCUSSION

Denial of quality healthcare services and policy outcomes of LSHIS

Access to healthcare is a crucial aspect, but the significance of healthcare quality cannot be overstated (Gordon, Booysen & Mbonigaba, 2020). The direct impact of quality healthcare services on health outcomes is undeniable, yet it is also contingent on individuals' financial capacities (Naher, Hoque, Hassan, Balabanova, Adams & Ahmed, 2020). To address this, the establishment of the LSHIS aimed

to ensure that all enrolled residents enjoy high-quality healthcare, regardless of their financial capabilities (LASHMA, 2020). However, the study's findings, along with those of Dele-Dada (2020) and Shobiye et al (2021), reveal a concerning pattern of denial of quality healthcare services within the scheme's implementation. This discrepancy has inadvertently led to unintended consequences, impacting the policy outcomes.

Despite the scheme's promise of quality healthcare, some participants are unable to fully benefit due to actions by certain healthcare providers, hindering the effective achievement of the scheme's objectives. This suggests that the scheme is not adequately accomplishing its goals for all participants. Nevertheless, the study indicates that, despite the challenges, some individuals still derive benefits from the scheme, indicating a moderate level of effectiveness. This aligns with the findings of Dele-Dada, Gberevbie & Owolabi (2024), who note varying outcomes among residents, with some experiencing improvements in healthcare services while the majority do not.

The study identifies resource constraints as a critical factor affecting the scheme's performance. Healthcare costs without insurance surpass the coverage provided by health insurance, and the provision of subsidized services is contingent on government reimbursement for the cost gap. Limited resources for both hospitals and patients impact the provision of quality healthcare. Challenges arise when insurance coverage is insufficient, especially for various ailments, including minor ones, leading to difficulties in sustaining care. The hospital's commitment to providing care, regardless of the patient's condition, often encounters challenges, with demands for additional payment from the government causing financial losses. These challenges are consistent with the findings of Shobiye et al (2021), indicating that both public and private healthcare providers face obstacles due to inadequate tariffs and delays in claims processing. Instances of non-reimbursement further complicate the scenario, as discrepancies between provided care and the agreed-upon scope in the government-provider agreement led to financial losses for healthcare service providers. Additionally, certain illnesses may not be covered by insurance, resulting in extra charges for treatment. As healthcare needs become more complex, additional expenses arise, making it unrealistic to expect complete coverage by insurance. The denial of quality healthcare services has triggered dissatisfaction among enrolled junior officers, leading to a shift in health insurance providers offering better services. Moreover, there is an increase in compensation claims for unresolved health issues, negatively impacting trust and perception among users.

Inequity in Healthcare Service Provision and policy outcomes of LSHIS

The findings of this study underscore the presence of disparities in access to healthcare, variations in care quality due to financial factors, age-related considerations, and instances of insurance misuse. Such issues are viewed with disapproval and are subject to thorough investigation for appropriate corrective measures. These findings align with the research conducted by Shittu & Afolabi (2020) and Dele-Dada (2020), both of which revealed substantial disparities in healthcare access within the Lagos State Health Scheme, pointing to structural deficiencies in its implementation.

These disparities manifest in unequal access, heightened expenditure, and compromised service quality, indicating systemic shortcomings. The complexity of inequity in healthcare provision is evident in this study's findings. While challenges exist in providing care for specific individuals, the primary determinants are resource availability and the nature of illnesses. Financial capacity emerges as a crucial consideration, influencing the level of care provided. Instances of individuals with insurance coverage encountering difficulties in receiving adequate attention, while those with greater financial means receive preferential treatment, have been observed. Unfair treatment based on financial capacity or other factors persists, particularly for individuals unable to afford additional payments beyond insurance coverage. This is especially problematic for those dealing with severe, progressive illnesses, encountering barriers to accessing adequate healthcare services.

Certain critical illnesses requiring specialized attention, potentially involving surgery, may not be covered under the insurance scheme. This creates a dilemma for individuals needing specialized care but lacking the financial means to cover extra expenses. In such situations, only individuals capable of self-payment receive attention, despite the presence of government hospitals in Lagos. Financial constraints faced by patients hinder their ability to receive necessary treatments, even for essential services for covered illnesses. Challenges during the reimbursement process, such as delays or inadequate funding from the government, disrupt the balance between expenditures and revenue. This, in turn, affects the hospital's ability to procure essential supplies and maintain optimal care standards. The repercussions of these challenges, including a lack of trust, accessibility problems, and instances of substandard care, are underscored. These issues directly undermine the scheme's objectives. The lack of trust resulting from delayed reimbursement and accessibility issues has broader implications, discouraging enrollment and participation. Individuals now question the legitimacy and fairness of the entire system, perceiving that the scheme falls short of its promise of equitable healthcare. This erosion of trust undermines the overall effectiveness of the policy, emphasizing the need for comprehensive reforms to address systemic issues and restore confidence in the healthcare system.

Discrimination in Healthcare Service Provision and Policy Outcomes of LSHIS

The findings gleaned from this study cast a focus on the unsettling dynamics of discrimination within the LSHIS, specifically targeting individuals with state-based and private insurance coverage. The resultant unequal access to healthcare services not only disrupts the fundamental principle of equity but also compromises the overarching goals of the health insurance scheme. The discrimination, though not explicitly intentional, stems from the disparities in insurance coverage, notably the comprehensive and costly nature of private health insurance. Despite the absence of overt discriminatory motives, the hospital tends to prioritize individuals who possess the financial means to pay, whether through out-of-pocket expenses or private insurance. This acknowledgment underscores the inherent disparities between private and government insurance, with the former often affording more extensive coverage. This preference for individuals with specific insurance coverages reflects a pragmatic decision-making approach influenced by the available resources. The limitations in resources mean that decisions are driven by practical considerations, particularly when confronted with cases that surpass the available resources. Moreover, the profit imperative has introduced an additional layer to this complex scenario, potentially leading to the prioritization of financially viable and more manageable cases over others. This finding is in line with the findings of Shobiye et al. (2021) in that that documented discriminatory practices based on a preference for those who can make out-of-pocket payments. Additionally, the authors observed a form of discrimination between those who possess state-based insurance and those who possess private health insurance, showing a preference for the latter. These occurrences highlight systemic obstacles and potential discrimination within the scheme.

The study further reveals that individuals with disabilities are not intentionally neglected, but rather their relative exclusion is a consequence of limitations in the coverage provided by the insurance scheme. The incomplete coverage of conditions related to disabilities, coupled with financial constraints, directs the focus of hospitals towards treating conditions that are more manageable and financially viable. Complex cases requiring extra payment pose challenges, especially for individuals unable or unwilling to cover additional costs. This financial prioritization unintentionally impacts the accessibility and quality of healthcare for those who cannot afford premium services, dissuading some enrollees from consistent utilization of the health insurance scheme.

The consequence of such discrimination in healthcare provision in the LSHIS is a palpable hindrance to receiving timely and appropriate care, which, in turn, potentially obstructs individuals from fully capitalizing on the benefits offered by the health insurance scheme. Moreover, this discriminatory

practice instills a sense of hesitation among some enrollees, fueled by concerns about potential bias from healthcare providers. This hesitation leads individuals to delay seeking medical attention until their conditions worsen, resulting in a suboptimal utilization of health services. It has also led to differential access to healthcare, barriers in attaining timely and appropriate care, and poorer health outcomes. However, it is important to note that the impact extends beyond the immediate health outcomes. Financially, enrollees face additional burdens when confronted with healthcare providers demanding extra monetary compensation. This discriminatory practice not only exacerbates the financial strain on individuals with insurance coverage but also undermines the effective implementation and enforcement of health insurance policies.

Continuous Out-of-Pocket Payments in Healthcare Service Provision and Policy Outcomes of LSHIS

The current emphasis on addressing common illnesses may fall short of adequately tackling the entire spectrum of health challenges documented in individuals' medical histories. For those grappling with severe or uncovered health conditions, the feasibility of affordability becomes compromised. In such cases, the inevitability of out-of-pocket payments persists, posing a significant hurdle to achieving universal affordability within the current framework. Regarding out-of-pocket payments for prescribed medications, situations arise where patients must procure the prescribed drugs externally due to the unavailability of certain medicines within the hospital's inventory. Consequently, the hospital issues prescriptions for patients to obtain the necessary medications elsewhere. This aligns with the findings of Robert et al (2018) and Shittu and Afolabi (2020), both of whom observed a persistent trend of enrolled residents facing escalating out-of-pocket expenses. Moreover, these individuals receive subpar healthcare services, with a preference shown towards those who can afford out-of-pocket payments.

The financial burden imposed by the scheme has the potential to diminish satisfaction and adversely impact the well-being of enrollees. In instances where specific required care is not covered by the scheme, obtaining medical attention may become challenging, acting as a barrier to essential healthcare access. Not all enrollees may be willing to shoulder additional healthcare costs, leading to potential delays or even forgoing necessary care. A notable concern raised is the substantial out-of-pocket expenses, which could result in non-adherence to recommended treatment plans or medications. This non-compliance poses a risk to the effectiveness of the health insurance policy, particularly in managing chronic conditions and preventing complications. If the perceived unaffordability of out-of-pocket expenses associated with the health insurance scheme persists, there is a tangible risk that the policy may be deemed ineffective in achieving its primary goals of enhancing overall health and reducing financial barriers to healthcare.

In essence, the findings underscore the challenges associated with out-of-pocket payments within the LSHIS, revealing a potential gap in addressing the diverse health needs of enrollees, particularly those facing severe or uncovered health conditions. The financial burden, coupled with the preference for those able to afford out-of-pocket payments, raises concerns about the scheme's ability to truly enhance accessibility, affordability, and overall well-being for all participants.

Recommendation

The following recommendations are based on the findings of the study:

Review and expand the coverage of the health insurance scheme to include a broader range of medical conditions, ensuring that all essential healthcare needs are addressed. This expansion should be designed in a way that is financially sustainable over time.

Establish robust quality assurance mechanisms to monitor and evaluate the performance of healthcare providers within the scheme.

Allocate additional resources to address the identified constraints affecting the performance of the scheme.

Establish financial assistance programs to support individuals facing extreme or uncovered health conditions, ensuring they have access to necessary healthcare services without significant financial burdens.

Introduce and enforce anti-discrimination policies within the LSHIS, explicitly prohibiting discrimination based on financial capacity, age, or health conditions. This would foster an inclusive and sustainable healthcare environment.

Utilize data-driven insights to continuously refine policies and address emerging challenges.

Implement incentive programs for healthcare providers within the scheme, rewarding quality service delivery, adherence to standards, and patient satisfaction.

CONCLUSION

This study constitutes a scholarly undertaking, systematically interrogating the complex dynamics of structural violence and its consequential effect on the policy outcomes of the Lagos State Health Insurance Scheme. The study reveals how increased out-of-pocket payments, inequity, inaccessibility, and discriminatory practices create latent barriers that hinder the realisation of equitable and inclusive healthcare outcomes. The findings highlight critical issues within the LSHIS, including resource constraints, disparities in access to healthcare, and discrimination against individuals with state-based and private insurance coverage. These issues result in significant financial burdens, substandard care, hesitancy among enrollees to seek timely medical attention, overdependence on traditional medicine, increased compensation claims, non-adherence to treatment plans, and a negative perception of the scheme. Additionally, the emphasis on common illnesses and the prioritisation of financially feasible cases intensifies the challenges faced by individuals with severe or uncovered health conditions. Thus, this scholarly pursuit transcends a mere academic exercise; rather, it functions as a resounding call to action directed at policymakers, healthcare professionals, and researchers. The collective imperative is to engage in concerted efforts aimed at dismantling structural impediments and cultivating a healthcare system that embodies genuine equity, accessibility, and justice.

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